# CITY OF MEMPHIS ACTIVE MEDICAL PLAN
# ENROLLMENT/CHANGE FORM

| Social Security No. __ __ __ - __ __ - __ __ __ __ | Date of Birth: | Gender: ___ Male ____ Female | Effective Date of Enrollment/Change: |
|---|---|---|---|

| Last name: | First name: | Middle initial |
|---|---|---|

Permanent residence street address (P.O. box is not allowed):

| City: | State: | ZIP code: | County: | Telephone Number: |
|---|---|---|---|---|

**B. REASON FOR ENROLLMENT/CHANGE:**

☐ I am enrolling during Annual Enrollment ☐ Qualifing Life Event (QLE)*

*You must submit this form along with required documentation within 60 days of the event date. Please Provide QLE and date of event:

A. **BENEFIT ELECTION – MEDICAL PLAN**

☐ **ENROLL IN COVERAGE** ☐ **CANCEL COVERAGE** ☐ **WAIVE COVERAGE** ☐ **CHANGE COVERAGE**

| Employee Section | Spouse Section | Dependent(s) Section |
|---|---|---|
| _____ Basic ____ Premier ___Value<br>___ I **Decline** the medical coverage for Employee | _____ Basic ____ Premier ___Value<br>___ I **Decline** the medical coverage for Spouse | _____ Basic ____ Premier ___Value<br>___ I **Decline** the medical coverage for Dependent |

**Please provide the information below for the dependents to be enrolled:**

| Last Name | First Name | M.I. | Social Security Number | Gender | Relationship |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**D. OTHER INSURANCE COVERAGE INFORMATION**

| Do you or any of your covered dependents have other medical coverage that's primary to the City's medical plan? **YES NO** | If covered by Medicare, please check what type(s): ☐ Part A ☐ Part B ☐ Full Medicare Both A & B |
|---|---|
| If Yes; Name of the Insured: | If Yes; Medicare A Effective Date: |
| Insurance Company Name: | Medicare B Effective Date: |
| Policy Number: | Reason for Medicare: ☐ Age ☐ Disability ☐ ESRD |
| Effective Date: | Medicare Claim Number: |

Employee's Signature: _____ Date: _____

**Health, Wellness & Benefits Office Use Only:**

| Enrollment Date: | Termination Date: | Employment Status: | Received By Date: | Entered By/Date: |
|---|---|---|---|---|
| | | | | |

# ACTIVE

**TO BE COMPLETED BY BENEFITS OFFICE:**
Effective Date: _____/_____/_____
Termination Date: _____/_____/_____

# VISION Plan Enrollment Form—CITY OF MEMPHIS

## I. Check the Appropriate Boxes

**Coverage Desired**
**EXAM/MATERIALS**
**SEMI-MONTHLY RATES**

- ☐ Employee Only $2.18
- ☐ Employee + 1 $4.00
- ☐ Employee + Family $6.79

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- ☐ New Enrollment
- ☐ Change of Status/Address
- ☐ Open Enrollment
- ☐ COBRA
- ☐ Cancel Coverage

**REASON FOR CHANGE IN STATUS**

- ☐ Termination
- ☐ Marriage
- ☐ Newborn Child
- ☐ Other Insurance
- ☐ Move to COBRA
- ☐ Death
- ☐ Divorce
- ☐ Last Name/Address Change
- ☐ Adoption/legal custody of child
- ☐ Legal custody of parent
- ☐ Dependent child married /reached age limit

## II. Employee Information (please print clearly):

Social Security Number _____ - _____ - _____ Birth Date_____/_____/_____

Your Name _____
(First) (Middle Initial) (Last)

Address _____

_____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

## III. List All Eligible Family Members Below (if electing dependent coverage):

| | First Name | Last Name | Birth Date | Social Security Number | Sex |
|---|---|---|---|---|---|
| Spouse | | | ____/____/____ | _____-_____-_____ | ☐M / ☐F |
| Child | | | ____/____/____ | _____-_____-_____ | ☐M / ☐F |
| Child | | | ____/____/____ | _____-____-_____ | ☐M / ☐F |
| Child | | | ____/____/____ | _____-_____-_____ | ☐M / ☐F |
| Child | | | ____/____/____ | _____-_____-_____ | ☐M / ☐F |

I agree to continue enrollment in the vision plan for a period of 12 month. I confirm that the information I have provided on this form is complete and accurate.

*Employee Signature*_____*Date*_____

***The Certificate of Coverage for Vision benefits is available online at http://www.memphistn.gov/framework.aspx?page=167 or Refer to the City of Memphis Health, Wellness & Benefits Service Center located at 2714 Union Avenue Ext. 5th Floor Room 100.***

# ACTIVE

# DENTAL Plan Enrollment Form—CITY OF MEMPHIS

**TO BE COMPLETED BY BENEFITS OFFICE:**
Effective Date: _____/_____/_____
Termination Date: _____/_____/_____

## I. Check the Appropriate Boxes

*Semi-Monthly Rates*

**Coverage Desired:**

**DPPO-PREMIER Dental Plan**

- ☐ Employee Only $9.75
- ☐ Employee + 1 $20.06
- ☐ Employee + Family $29.19

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**DHMO-BASIC Dental Plan**

- ☐ Employee Only $6.21
- ☐ Employee + 1 $10.56
- ☐ Employee + Family $16.87

- ☐ New Enrollment
- ☐ Change of Status/Address
- ☐ Open Enrollment
- ☐ COBRA
- ☐ Cancel Coverage

**REASON FOR CHANGE IN STATUS**

- ☐ Termination
- ☐ Marriage
- ☐ Newborn Child
- ☐ Other Insurance
- ☐ Move to COBRA
- ☐ Death
- ☐ Divorce
- ☐ Last Name/Address Change
- ☐ Adoption/legal custody of child
- ☐ Legal custody of parent
- ☐ Dependent child married/reached age limit

## II. Employee Information (please print clearly):

Social Security Number _____ - _____ - _____ Birth Date_____/_____/_____

Your Name _____
(First) (Middle Initial) (Last)

Address _____

_____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

## III. List All Eligible Family Members Below (if electing dependent coverage):

| | First Name | Last Name | Birth Date | Social Security Number | Sex |
|---|---|---|---|---|---|
| Spouse | | | ____/____/____ | _____-_____-_____ | ☐M / ☐F |
| Child | | | ____/____/____ | _____-_____-_____ | ☐M / ☐F |
| Child | | | ____/____/____ | _____-____-_____ | ☐M / ☐F |
| Child | | | ____/____/____ | _____-_____-_____ | ☐M / ☐F |
| Child | | | ____/____/____ | _____-_____-_____ | ☐M / ☐F |

I agree to continue enrollment in the vision plan for a period of 12 month. I confirm that the information I have provided on this form is complete and accurate.

*Employee Signature* _____ *Date*_____

***The Certificate of Coverage for Vision benefits is available online at http://www.memphistn.gov/framework.aspx?page=167 or Refer to the City of Memphis Health, Wellness & Benefits Service Center located at 2714 Union Avenue Ext. 5th Floor Room 100.***

# City of Memphis
# Flexible Benefit Plans
## Enrollment Form

**Health, Wellness & Benefits Office**
**2714 Union Avenue Ext. 5th Floor Room 100**
**Memphis, Tennessee 38112**
**Phone: (901) 636-6800**
**Fax: (901) 636-8486**

Change Type: Date of Event _____/_____/____

- Address/Name change
- New Hire
- Termination (must complete COBRA form*)
- Change in Status _____

*For out-of-Pocket Medical Expense account participants

**Please call Cigna Healthcare if you have any questions** **1-800- CIGNA24 or 1-800-244-6224**

**1 Employee Information**

| **Social Security Number** - - | **Email Address** |
|---|---|
| **Employee Name (Last, First, Middle Initial)** | |
| **Street Address** | |
| **City, State, Zip Code** | |

**Plan Year: From** ____/_____/_____

**To** _____/____/_____

**Effective Date** _____/_____/_____

**2 Flex Benefit Election**

☐ I hereby elect to participate in the Flex Benefit Plan offered by my Employer, thereby paying my expenses with before-tax dollars. I hereby authorize my Employer to reduce my income subject to taxes in the total amount stated below for the above Plan Year. If my group insurance requires a change in my contribution during the Plan Year I authorize my Employer to make the contribution adjustments.

**I. Health Care Spending Account** **$ _____ - _____ = $_____**
(Expenses for Medical, Dental, Vision, etc.) Election Amount # of Pay Periods Amount Per Pay Period

**II. Dependent Care Spending Account** **$ _____ - _____= $_____**
Election Amount # of Pay Periods Amount Per Pay Period

Do you or any of your family members participate in a Health Savings Account (HSA)? Yes No
*(If yes, an out-of-pocket medical expense FSA is not available.)*

☐ I hereby elect NOT to participate in the Flex Benefit Plan offered by my Employer, thereby paying my expenses with after-tax dollars. I also understand that I will have an opportunity to make a new election, if I so desire, prior to the beginning of each subsequent Plan year, in accordance with the procedures described in the Plan Document.

**3 Signature and Acknowledgement - Please read before signing**

This agreement will remain in effect for the Plan year unless changed for reasons stated in the terms and conditions of the Plan. By affixing my signature below, I certify that I have examined this agreement and understand and agree to comply with the terms and conditions of the Plan. If this is a change in status, I certify that this change is consistent with the qualifying event. I agree to hold Cigna Healthcare and my Employer harmless from any liability to my participation in this plan.

**SIGNATURE** **DATE**

**NOTARIZED SIGNATURE OR HWBENEFITS REPRESENTATIVE** **DATE**